

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/04/2019
NAME OF PROVIDER OR SUPPLIER  MOUNT SINAI MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  4300 ALTON RD MIAMI BEACH, FL 33140		
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A 000	<p>INITIAL COMMENTS</p> <p>An unannounced federal complaint survey, complaint number: 2019008293, was conducted on 05/29/2019 to 05/30/2019 and 06/04/2019 at Mount Sinai Medical Center, which is located at 4300 Alton Road, Miami, FL 33140 to review the Conditions of Participation: Patient Rights, Governing Body and Quality Assessment Performance Improvement (QAPI).</p> <p>Mount Sinai Medical Center was not in compliance with the Federal Regulations at 42 CFR 482 requirements for Acute Care Hospitals.</p> <p>Immediate Jeopardy was identified on 05/29/2019 and ongoing at the Condition of Participation: Patient Rights A-115.</p> <p>Condition level deficiencies were identified at: QAPI A-263, and Governing Body A-43.</p>	A 000		
A 043	<p>GOVERNING BODY CFR(s): 482.12</p> <p>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...</p> <p>This CONDITION is not met as evidenced by: Based on record reviews, staff interviews, and review of policies, the governing body failed to maintain responsibility for the conduct of the hospital employees and ensure the effectiveness of the person(s) responsible for the conduct of the hospital employees resulting in an incident of sexual assault involving one patient (SP #1) of 4</p>	A 043		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043  A 057	<p>Continued From page 1 sampled patients (SP). (Refer to A-0057)</p> <p>CHIEF EXECUTIVE OFFICER CFR(s): 482.12(b)</p> <p>The governing body must appoint a chief executive officer who is responsible for managing the hospital.</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interviews and review of policies the governing body failed to maintain responsibility for ensure the effectiveness of person(s) responsible for the conduct of the hospital employees resulting in an incident of sexual assault involving one patient (SP #1) of 4 sampled patients (SP).</p> <p>Findings include:</p> <p>Clinical Record review of sample patient (SP) #1, revealed she arrived in the ER (Emergency Room) on 11/05/2019 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal ideation. She was admitted to the Behavioral Health Unit on 11/06/2018 at 11:00 AM.</p> <p>Review of Behavioral Health Nursing Notes of the Primary Nurse/Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified. Evidence collected by law enforcement for analysis. Patient was to be transported to rape trauma center at [named] Hospital for evaluation</p>	A 043  A 057		

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A 057	<p>Continued From page 2 as recommended by law enforcement.</p> <p>In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed on 11/05/2018, patient complained of being sexually assaulted by a Mental Health Technician (MHT) and identified employee by name. The police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee. Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the hospital administration was informed that the DNA sample taken from the patient matched the DNA taken from the employee and the employee was arrested. The following day, Thursday, 05/23/2019, the Vice President Risk Management and the Director Risk Management notified the Joint Commission but did not notify the Department of Children's and Families. The DNA findings were consistent with the police report, on the breast and the in the vagina. The actual results were not provided to the facility.</p> <p>Interview with Clinical Director Behavioral Health on 05/29/2019 at 3:02PM revealed the employee Staff A attended a 1-day training on 05/22/2019 and went to police station. This was the last day of work for the employee. The Clinical Director Behavioral Health had a staff meeting on 11/15/2018, to discuss mandatory education on abuse and neglect and remind staff about not entering patient rooms alone. Review of</p>	A 057		

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A 057	<p>Continued From page 3</p> <p>Behavioral Health General Staff Meeting Agenda documented on 11/15/2018 revealed</p> <p>Findings/Conclusions: Only enter patient room alone when doing rounds or quickly completing duties/tasks. Do not have 1:1 conversations alone in room, this is regardless of gender. This is the best way to protect yourself from allegations and possible physical violence.</p> <p>Recommendations/Action: Longer conversations or 1:1 support should be given in hallway or dining rooms (anywhere on camera). Any longer activity, get second staff. No students or Non-behavioral health staff to be left alone with patients. Accompany them to rooms. Review of Department of Psychiatry/Behavioral Health Sign-in sheet revealed approximately 51 signatures out of approximately 86 staff members in attendance. No policy was written or corrective action plan was implemented after the incident.</p> <p>Interview with Clinical Director Behavioral Health on 06/04/2019 at 11:03AM revealed the incident has not been presented to the Board but the report is in draft to be presented at the next meeting.</p>	A 057		
A 115	<p>PATIENT RIGHTS CFR(s): 482.13</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This CONDITION is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility failed to provide care in a safe setting, and ensure the patient's right to be free from all forms of (sexual) abuse in 1 (SP #1) out of 4 sample patients (SP). The hospital's failure to prevent abuse resulted in an</p>	A 115		

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A 115	Continued From page 4  employee sexually assaulting a patient. The hospital's failure to ensure patients are free from abuse, sexual assault by employees providing care and services resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate corrective action on the part of the hospital. (Refer to A-0144 and A-0145)	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)  The patient has the right to receive care in a safe setting.  This STANDARD is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility failed to provide care in a safe setting, in 1 (SP #1) out of 4 sample patients (SP). The hospital's failure to ensure the employee provide care and services in a safe setting resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate correction action on the part of the hospital.  The findings include:  Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified.	A 144		

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A 144	<p>Continued From page 5</p> <p>Evidence collected by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended by law enforcement.</p> <p>In an interview with (Primary Nurse) Staff-D via telephone on 05/29/2019 at 3:25 PM revealed that nurse was in the hallway when the patient was yelling and mentioned that the Spanish guy raped me.</p> <p>Review of Staff-A Disciplinary Action documented on 11/15/2018 that Reason: failure to follow protocol. On Wednesday, November 7, 2018, employee had 1:1 conversation with patient in room with no other staff present. Patient later made allegations against staff member, and due to the break in protocol (no other staff members present, interaction no captured on camera), police had to be called to conduct investigation into patient allegations. Police investigated patient allegations, and cleared staff of any wrongdoing. The escalation of this issue could have been avoided if employee had followed protocol. Employee was suspended unpaid on Thursday, 11/08/2018 for one day and received written counseling signed 11/19/2018.</p> <p>In an interview with Clinical Director Behavioral Health Unit on 05/29/2019 at 12:41PM revealed that unless the staff is doing every 15 minute rounding or 1:1, despite gender, at any time in the room they should have a witness (another staff member) with them.</p> <p>The employee returned to direct patient care in the behavioral health department (to include the inpatient unit and the emergency department psyche area) pending the results of the DNA</p>	A 144		

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A 144	<p>Continued From page 6 sample.</p> <p>Review of clock punches for period 11/01/2018 - 11/30/2018 revealed patient worked Wednesday, 11/07/2018, (date of incident). Employee was suspended unpaid on Thursday, 11/08/2018, and returned to regular work schedule on Friday, 11/09/2018.</p> <p>The facility's administration was notified on 05/22/2019 that the DNA sample taken from the patient matched the DNA taken from the employee and the employee was issued a termination letter on 05/23/2019.</p> <p>Interview with Behavioral Health Unit Director on 05/29/2019 at 3:02PM revealed employee was assigned to psyche intake unit in the ED. In this role, the tech assisted with admission documentation and transported patients from the ED to the inpatient psyche unit and if it is not busy in the ED, staff is asked to help in the inpatient unit.</p> <p>The Behavioral Health policy with the title: "Suspected Patient Abuse/Neglect, 16.4.021," (revised date: 05/2019) states all patients admitted to the Department of Psychiatry/Behavioral Health Unit shall be protected from abuse of any kind including physical roughness, verbal threats or harassment,. DEFINITION: SEXUAL ABUSE - Sexual abuse includes any sexual overtur made to a patient verbal or physical irrespective of patient's willingness to be involved in it.</p>	A 144		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3)	A 145		

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A 145	<p>Continued From page 7</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, and review of policies, the facility failed to ensure the patient's right to be free from all forms of (sexual) abuse in 1 (SP #1) out of 4 sample patients (SP). The hospital's failure to ensure patients are free from abuse (sexual assault) by an employee providing care and services resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate correction action on the part of the hospital.</p> <p>The findings include:</p> <p>The Census: on 11/07/2018, for the 3:00 PM -11:00 PM shift, was 21 patients with 8 females.</p> <p>Clinical Record review of sample patient (SP) #1, revealed she arrived in the ER (Emergency Room) on 11/05/2018 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal ideation. She was admitted to the Behavioral Health Unit on 11/06/2018 at 11:00 AM.</p> <p>Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room. Charge nurse and attending psychiatrist made aware. Police notified. Evidence collected</p>	A 145		

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A 145	<p>Continued From page 8</p> <p>by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended by law enforcement.</p> <p>Review of Police Report of SP #1 documented on 11/07/2018 at 7:30 PM to 8:00 PM showed that officers responded to the hospital psych ward in reference to a female patient accusing a male employee of the hospital touching her against her will. Officers made contact with complainant who stated that one of the male employees touched her inappropriately in various places about her body. According to patient, the male employee (later to be known as Staff-A) came into her room and began a conversation with her, while he was eating his dinner. Sometime during the conversation, the employee approached her and caressed her breast. Patient then stated that employee took her hand and forcefully placed her hand on his penis. The employee left the room soon after. The patient then stated that the employee came back to the room approximately 15-20 minutes later and made another advance by kissing and caressing her breast then touching her inappropriately by placing his (wet/saliva) hand on her vagina. The employee allegedly took a picture of the patient while she was getting dressed before leaving the room. Officers made contact with the employee who admitted to having a conversation with the patient, but denied any physical contact with the female.</p> <p>Review of Staff-A clock punches documented on 11/01/2018 to 11/30/2018 that employee worked Wednesday, 11/07/2018, (date of incident) and returned to regular work schedule on Friday, 11/09/2018 to 05/22/2019 prior to the DNA results.</p>	A 145		

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A 145	<p>Continued From page 9</p> <p>Review of 4 Warner Southeast Corridor (Female Wing) video footage of Staff-A and SP #1 on 06/04/2019 revealed that Staff-A entered and exited the room of SP #1 on 11/07/2018 at the following times:</p> <ol style="list-style-type: none"> <li>1. Staff-A Entered: 7:04:40 PM, Staff-A Exited: 7:07:45 PM</li> <li>2. Staff-A Entered: 7:08:23 PM, Staff-A Exited: 7:11:06 PM</li> <li>3. Staff-A Entered: 7:12:47 PM, Staff-A Exited: 7:14:20 PM</li> <li>4. SP #1 in hallway at 7:23:48 PM and returns to room at 7:26:04 PM</li> <li>5. Staff-A in hallway speaking with SP #1 at 7:31:38 PM</li> <li>6. SP #1 enters room at 7:31:44 PM and Staff-A follows, Staff-A Exited: 7:32:16 PM</li> <li>7. SP #1 out of room at 7:32:22 PM and returns to room at 7:32:26 PM</li> <li>8. Staff-A walks down the hallway and SP #1 follows at 7:33:20 PM</li> <li>9. SP #1 enters room at 7:33:40 PM</li> <li>10. Staff-A Entered: 7:33:47 PM, Staff-A Exited: 7:35:23 PM</li> <li>11. Staff-A Entered: 7:35:27 PM, Staff-A Exited: 7:35:58 PM</li> <li>12. SP #1 out of room at 7:37:00 speaks with employees and nursing station and returns to room at 7:41:35 PM</li> <li>13. SP #1 observed in and out of room multiple times and pacing the hallway from at 7:42 PM to 7:55 PM</li> <li>14. Police observed at 8:49:22</li> </ol> <p>In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed on 11/05/2018, patient complained of being sexually assaulted by a Mental Health Technician (MHT) and identified employee by name. The</p>	A 145		

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A 145	<p>Continued From page 10</p> <p>police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee.</p> <p>Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the hospital administration was informed that the DNA sample taken from the patient matched the DNA taken from the employee and the employee was arrested. The following day, Thursday, 05/23/2019, the Vice President Risk Management and the Director Risk Management notified the Joint Commission but did not notify the Department of Children's and Families. The DNA findings were consistent with the police report, on the breast and the in the vagina.</p> <p>In an interview with Director Risk Management on 05/29/2019 at 12:15 PM revealed that the police stated the allegations were unfounded, patient had history of reporting allegations of the same nature and from their end employee was cleared until the results of the DNA testing.</p> <p>In an interview with (Primary Nurse) Staff-D via telephone on 05/29/2019 at 3:25 PM revealed that nurse was in the hallway when the patient was yelling and mentioned that the Spanish guy raped me. Nurse calmly approached patient and listened to the complaint. Nurse and patient talked and the patient gave the description that the mental health technician had entered the patient's room but did not go into detail about what had happened.</p>	A 145		

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NAME OF PROVIDER OR SUPPLIER  <b>MOUNT SINAI MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>4300 ALTON RD MIAMI BEACH, FL 33140</b>	
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A 145	<p>Continued From page 11</p> <p>Interview with (Charge Nurse) Staff-E via telephone on 5/29/2019 at 3:35PM revealed that the patient was by the room door complaining. The charge nurse notified the Clinical Director Behavioral Health whom instructed the charge nurse to call the police department. The employee was assigned to work in the emergency department psyche intake area and had brought 5 admissions from the emergency department to the behavioral health unit during the 3P-11P shift.</p> <p>The Behavioral Health policy with the title: "Victims of Abuse, Assault or Neglect, 16.4.008," (revised date: 05/2019) states that the department of psychiatry/behavioral health shall strive to identify, treat and report all cases of abuse, assault or neglect. This included, but is not limited to, adult and elder abuse and neglect, domestic violence, victims of crime and sexual molestation. Staff Education: 1. All staff in the department will receive initial and ongoing training in identifying possible victims of abuse, assault or neglect. 2. Any employee who knows, or has reasonable cause to suspect that an aged person or disabled adult is or has been abuses, abandoned, neglected, or exploited, shall immediately report such knowledge or suspicion to the Director. Director or designee must notify the Central Abuse Hotline of the Department of Children and Family Services via 1-800-96-ABUSE (1-800-962-2873).</p> <p>The Behavioral Health policy with the title: "Suspected Patient Abuse/Neglect, 16.4.021," (revised date: 05/2019) states all patients admitted to the Department of</p>	A 145		

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A 145	<p>Continued From page 12</p> <p>Psychiatry/Behavioral Health Unit shall be protected from abuse of any kind including physical roughness, verbal threats or harassment., DEFINITION: SEXUAL ABUSE - Sexual abuse includes any sexual overtur made to a patient verbal or physical irrespective of patient's willingness to be involved in it.</p> <p>The Behavioral Health policy title:d "Abuse Reporting: External and Internal Events, 16.4.015, (revised date: 06/2016) states that the incident shall be reported to the Abuse registry at 1-800-96-ABUSE immediately after the Chairman of the Department and/or Nurse Director are informed of the matter. Documentation in the patient's medical record shall include the time of call, supportive information, and any follow-up contact.</p>	A 145		
A 263	<p>QAPI CFR(s): 482.21</p> <p>The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.</p> <p>The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.</p> <p>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p>	A 263		

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A 263	Continued From page 13  This CONDITION is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility Quality Assessment and Performance Improvement Program failed to develop, identify opportunities for improvement and have an Action Plan aimed at performance improvement; and provide clear expectations for safety as a result of an incident of sexual assault involving a patient (SP #1) of 4 sampled patients (SP). (Refer to A-0283 and A-0286).  QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)  (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement.  (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care.  (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 263	A 283	

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A 283	<p>Continued From page 14</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interviews, and review of policies the facility failed to fully implement the Quality Assessment and Performance Improvement Action Plan aimed at performance improvement as a result of an a sexual assault incident involving 1 (SP #1) of 4 sampled patients (SP).</p> <p>The findings include:</p> <p>The Census: on 11/07/2018, for the 3:00PM -11:00PM shift, was 21 patients with 8 females.</p> <p>Clinical Record review of sample patient (SP) #1, revealed she arrived in the ER (Emergency Room) on 11/05/2019 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal ideation. She was admitted to the Behavioral Health Unit on 11/06/2018 at 11:00 AM.</p> <p>Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified. Evidence collected by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended by law enforcement.</p> <p>In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed on 11/05/2018, patient complained of being</p>	A 283		

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A 283	<p>Continued From page 15</p> <p>sexually assaulted by a Mental Health Technician (MHT) and identified employee by name. The police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee.. Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the hospital administration was informed that the DNA sample taken from the patient matched the DNA taken from the employee and the employee was arrested. The following day, Thursday, 05/23/2019, the Vice President Risk Management and the Director Risk Management notified the Joint Commission but did not notify the Department of Children's and Families. The DNA findings were consistent with the police report, on the breast and the in the vagina. The actual results were not provided to the facility.</p> <p>Interview with Clinical Director Behavioral Health on 05/29/2019 at 3:02PM revealed the employee Staff A attended a 1-day training on 05/22/2019 and went to police station. This was the last day of work for the employee. The Clinical Director Behavioral Health had a staff meeting on 11/15/2018, to discuss mandatory education on abuse and neglect and remind staff about not entering patient rooms alone. Review of Behavioral Health General Staff Meeting Agenda documented on 11/15/2018 revealed</p> <p>Findings/Conclusions: Only enter patient room alone when doing rounds or quickly completing duties/tasks. Do not have 1:1 conversations alone</p>	A 283		

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A 283	<p>Continued From page 16</p> <p>in room, this is regardless of gender. This is the best way to protect yourself from allegations and possible physical violence.</p> <p>Recommendations/Action: Longer conversations or 1:1 support should be given in hallway or dining rooms (anywhere on camera). Any longer activity, get second staff. No students or Non-behavioral health staff to be left alone with patients. Accompany them to rooms. Review of Department of Psychiatry/Behavioral Health Sign-in sheet revealed approximately 51 signatures out of approximately 86 staff members in attendance. No policy was written or corrective action plan was implemented after the incident.</p> <p>The Policy titled: "Sentinel Events and Significant Occurrences, 1.28.026," (revised date: 06/2018) states that sexual abuse/assault including "rape" is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patients sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event: Any staff witnessed sexual contact as described above, sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact or admission by the perpetrator that sexual contact, as described above, occurred on the premises. A thorough and credible Root Cause Analysis will be conducted for any Sentinel Event as defined in this policy. The hospital disseminates lessons learned from root cause analyses, system or process failures to all staff who provide services for the specific situation.</p>	A 283		

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A 286 A 286	<p>Continued From page 17</p> <p><b>PATIENT SAFETY</b></p> <p>CFR(s): 482.21(a), (c)(2), (e)(3)</p> <p>(a) Standard: Program Scope</p> <p>(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors.</p> <p>(2) The hospital must measure, analyze, and track ...adverse patient events ...</p> <p>(c) Program Activities .....</p> <p>(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.</p> <p>(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...</p> <p>(3) That clear expectations for safety are established.</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility governing body failed to assume responsibility in setting clear expectations for safety as a result of an incident of sexual assault involving a patient (SP #1) of 4 sampled patients (SP).</p> <p>The findings include:</p> <p>Clinical Record review of sample patient (SP) #1,</p>	A 286 A 286		

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A 286	<p>Continued From page 18</p> <p>revealed she arrived in the ER (Emergency Room) on 11/05/2019 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal ideation. She was admitted to the Behavioral Health Unit on 11/06/2018 at 11:00 AM.</p> <p>Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified. Evidence collected by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended by law enforcement.</p> <p>In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed on 11/05/2018, patient complained of being sexually assaulted by a Mental Health Technician (MHT) and identified employee by name. The police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee.. Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the hospital administration was informed that the DNA sample taken from the patient matched the DNA taken from the employee and the employee</p>	A 286		

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A 286	<p>Continued From page 19</p> <p>was arrested. The following day, Thursday, 05/23/2019, the Vice President Risk Management and the Director Risk Management notified the Joint Commission but did not notify the Department of Children's and Families. The DNA findings were consistent with the police report, on the breast and the in the vagina. The actual results were not provided to the facility.</p> <p>Interview with Clinical Director Behavioral Health on 05/29/2019 at 3:02PM revealed the employee Staff A attended a 1-day training on 05/22/2019 and went to police station. This was the last day of work for the employee. The Clinical Director Behavioral Health had a staff meeting on 11/15/2018, to discuss mandatory education on abuse and neglect and remind staff about not entering patient rooms alone. Review of Behavioral Health General Staff Meeting Agenda documented on 11/15/2018 revealed</p> <p>Findings/Conclusions: Only enter patient room alone when doing rounds or quickly completing duties/tasks. Do not have 1:1 conversations alone in room, this is regardless of gender. This is the best way to protect yourself from allegations and possible physical violence.</p> <p>Recommendations/Action: Longer conversations or 1:1 support should be given in hallway or dining rooms (anywhere on camera). Any longer activity, get second staff. No students or Non-behavioral health staff to be left alone with patients. Accompany them to rooms. Review of Department of Psychiatry/Behavioral Health Sign-in sheet revealed approximately 51 signatures out of approximately 86 staff members in attendance. No policy was written or corrective action plan was implemented after the incident.</p> <p>The Policy titled: "Sentinel Events and Significant</p>	A 286		

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A 286	Continued From page 20  Occurrences, 1.28.026, " (revised date: 06/2018) states that sexual abuse/assault including "rape" is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patients sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event: Any staff witnessed sexual contact as described above, sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact or admission by the perpetrator that sexual contact, as described above, occurred on the premises. A thorough and credible Root Cause Analysis will be conducted for any Sentinel Event as defined in this policy. The hospital disseminates lessons learned from root cause analyses, system or process failures to all staff who provide services for the specific situation.	A 286		